phied; the surface was studded with white points. The iodine test showed the presence of amyloid degeneration.

It is to be regretted that no examination of the head was made, as it would undoubtedly add very much to the value of the case if we knew positively, what we cannot do otherwise than infer, that the paralysis with which the patient was at various times affected, and the chorea which occurred just previously to his death, were caused by emboli in the smaller branches of the cerebral arteries.

Microscopical Examination by Dr. J. G. Richardson.—The kidneys, which had undergone most marked contraction, showed beneath the microscope a peculiar appearance of the Malpighian corpuscles, whose convolutions were filled with a transparent refractive substance, having a waxy lustre, and becoming of a bright red color when acted on by an aqueous solution of iodine.

The uriniferous tubules were, in many portions of the specimens examined, filled with a similar matter, which assumed an analogous tint, though less intense under the application of iodine.

The smaller arteries around which the Malpighian corpuscles were closely clustered, were decidedly thickened, and exhibited much greater rigidity of their walls than normally exists.

Dr. ALLEN exhibited the leg of a patient, in whom amputation was performed on account of varicose veins, and who died precisely two weeks after the operation from "heart clot."

June 10. *Colloid Cancer, involving Substance of Peritoneum and Lymphatic Glands, more particularly along the Vertebral Column, and, to a less degree, also the Pleura.* Dr. WILLIAM PEPPER presented the specimen and read the following history:—

—— ——, æt. about 40, a postman, who had enjoyed general good health, with exception of an attack of malaria and diarrhœa, about 1865, while in army, and a severe attack of jaundice, some years before, from which, however, he entirely recovered without any unpleasant sequelæ, began to notice, in early part of 1868, a swelling in lower part of abdomen. This increased steadily but slowly, without any disturbance of general health.

His account of the beginning of the attack was, that it originated with acute symptoms: violent pain at first in right side, but soon extending over the whole abdomen; vomiting, scanty urine, great sense of prostration. These symptoms subsided after a week or ten days, and left considerable enlargement of the abdomen. As will be gathered from further description of the case, it is probable that they were due to rupture of a small cyst and consequent peritonitis.

There was for some months little or no emaciation or loss of strength; appetite remained good, and he was merely troubled with occasional sense of epigastric distress and tension. No alteration of urine, which was repeatedly examined and always found healthy. Bowels usually costive, requiring use of laxatives.

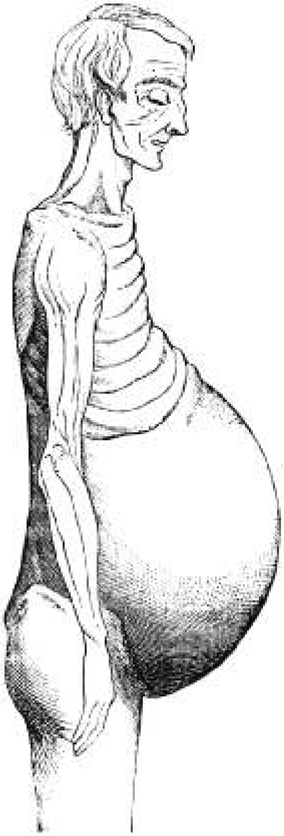
He had his clothes made so as to accommodate the growing tumour, and continued on his round delivering letters.

Towards close of 1868, enlargement became so great as to much incommode him—his abdomen being, at that time, as large as a woman at full term. He was then tapped in median line some inches above pubis, and several pints of serous fluid drawn off. The wound healed quickly, and he returned to his work. In a few months (middle of February, 1869) it became necessary to tap him again. There was then distinct fluctuation in various directions in the abdomen; though it was evident that there was a tumour in addition to the free peritoneal fluid. Paracentesis was again performed by Dr. Levis; the trocar being introduced to the left of the median line and higher up. When first introduced, about f℥ij of pinkish serum with little shreds of lymph were discharged, and the flow then stopped. On withdrawing the trocar, the direction of its point was changed slightly, and a puncture made through a thin walled cyst, which discharged several ounces of transparent, almost colourless, viscid fluid—which became a firm, solid, trembling jelly on exposure.

The first fluid was highly albuminous, contained chloride of sodium and urea, and deposited a very few large round granular nucleated cells.

The colloid material was not examined carefully. The puncture oozed for some time, but healed nicely. The operation did not cause much reduction in his size, but rather merely a subsidence of one portion of abdomen which had been unusually prominent.

In March, his general health was evidently suffering much. He lost flesh and strength; had no hectic nor sweats; no cachectic appearance; no jaundice, no appearance of marked leucocythæmia; appetite rather poor, and unable to gratify it from ensuing distension; respirations superior costal, and he is unable to lie down on back, though he can lie on either side. No cough or sputa; heart healthy; urine continues normal in quantity and quality, passed somewhat too frequently; bowels costive, opened by laxatives.



His appearance at this time was remarkable. Arms and chest quite emaciated, though not extremely so; legs œdematous from venous obstruction; abdomen enormously distended (see sketch), entirely symmetrical; enlargement projected laterally and anteriorly; projection at epigastrium singularly abrupt, and the ensiform cartilage was bent forwards at a right angle. The whole base of the chest was expanded. The liver and heart were pushed upwards.

There was no tenderness over abdomen, excepting at and near epigastrium, and in neighbourhood of point of puncture in second operation.

Palpation did not elicit fluctuation from one side of the abdomen to the other, but in several portions of the abdomen, as in right side and just above umbilicus, there was distinct fluctuation. Strong palpation caused no sense of shock.

There was dulness on percussion over the entire front and lateral aspects of the chest, the only resonance being found in lumbar regions, and most markedly in either when he lay upon the opposite side.

The veins of the abdominal walls were somewhat distended.

The patient urgently insisted upon an operation being performed for his relief; and as, in middle of April, the tumour was enlarging; œdema and discoloration of legs increasing rapidly; cutaneous veins of abdomen enormously distended on lateral aspect of abdomen, and dyspnœa becoming urgent; an exploratory incision was made by Dr. Levis in median line, about half a gallon of peritoneal fluid evacuated, and an enormous tumour (described below) found filling the abdominal cavity, and entirely inseparable from its attachments to all the viscera. The operation was abandoned; the incision closed, and the patient died in three days.

Diagnosis.—The history of a severe attack of jaundice might have turned the attention to the liver, but the entire absence of any permanent disturbance of its function proved that there was no organic disease of its tissue; while the character of the fluid drawn off conclusively showed that it was not a hydatid growth. The absence of leucocythemia or extreme anæmia, the symmetrical character of growth, and the fact that it began in lower part of abdomen, excluded the idea of a splenic cyst.

The absence of any renal symptoms, hæmaturia or albuminuria, rendered it certain that both kidneys were not involved; and the symmetrical character of the growth rendered it improbable that it could depend upon hydronephrosis of one kidney. Yet the manner in which he described the symptoms of the acute attack in beginning of his sickness, made it resemble somewhat an attack of nephritic colic.

The absence of any cancerous cachexia also, such as might be presumed would attend extensive colloid cancer, made it probable that it was a purely cystic disease.

And the existence of urea in the fluid withdrawn by paracentesis, which was believed at that time to come from a cyst, and not to be peritoneal effusion, also tended to direct suspicion to the kidney.

Consequently the diagnosis rested between enormous hydronephrosis principally of one kidney, and cystic disease of the omentum.

Autopsy.—Thorax and abdomen alone examined.

Upon cutting through the abdominal walls, the peritoneal cavity was found to a great extent obliterated by close and strong adhesions between the parietal peritoneum and the tumour below described. Upon forcibly breaking up these adhesions, the parietal peritoneum was found thickened and studded over with numerous nodules. The entire abdominal cavity was filled by a huge mass, which extended far up into concavity of diaphragm, and downwards into pelvic cavity. This morbid growth was quite symmetrical, and upon close examination proved to be composed chiefly of the greater omentum, with some additional outlying masses. The omentum was enormously hypertrophied, being at least five inches in thickness, and reaching from the epigastrium down to the pubes. Its anterior surface was invested by a thick opaque white membrane. Upon cutting into it, its structure was found to be composed of a stroma of dense fibrous tissue, arranged so as to leave cystic cavities of varying sizes, some being barely visible to the naked eye, and others having a diameter of several inches. The fibrous septa separating these cavities were firm, but rarely thick. The inner surface of the large cavities presented a smooth, serous appearance. The contents of all the cavities were of a thick jelly-like character, varying in colour from a light amber to a decided red. The lateral borders of this mass were rounded, but the lower margin presented innumerable cystic nodules, varying in size from one-twelfth of an inch to one inch in diameter, and containing a similar gelatinous substance. In some places these nodules were partially imbedded in a stroma, but in others they seemed attached to each other merely by delicate fibrous strings. Upon raising this mass, the intestines were found matted together, and imbedded in similar colloid growth. The glands along the vertebræ were enlarged, and a section presented an areolar structure, exuding colloid material. There was an enlarged gland in left groin presenting a similar degeneration.

The abdominal viscera, liver, spleen, and kidneys, presented no positive disease of their structure. There were, however, several very large nodules, 1½ to 3 inches in diameter, of firm colloid growth, attached to under surface of liver; and on left side of abdomen there was a large mass, six inches in diameter, extending from left border of the greater omentum to inner surface of spleen, which was probably the diseased and enlarged lesser omentum.

The peritoneum lining the concavity of the diaphragm was studded over with large and small nodules, which were adherent to and had produced depressions in the concavity of the liver.

Similar nodules were found springing from the pleura investing the diaphragm, especially in the right thorax. The bronchial glands were very much enlarged, and presented colloid degeneration, and there were several small nodules loosely attached to the pulmonary pleuræ. There was, however, no disease of the tissue of the lungs.[1]

It will be observed that, with the exception of the lymphatic glands, the disease was limited to the substance and surface of the serous membranes.

Microscopic examination of the colloid material from one of the cystic cavities in the omentum showed numbers of quite large cells, round, oval, or polygonal, and occasionally aggregated in small plates, like epithelium; with delicately granular contents, and presenting a single clear nucleus. In some instances, the nucleus filled the containing cell almost entirely, so that the cell seemed to have a double contour; in other cases, the nucleus filled the greater part of the cell, leaving a crescent-shaped cavity between the cell-wall and itself. In all these cells, the nuclei themselves were granular, and the surrounding portion of cell was clear.

Examination of a small and unusually firm nodule, whose surface on section showed very few cysts visible to the naked eye, but exuded a glutinous colloid substance, showed a dense stroma of unusually long and closely intertwined fibres, which were pale and flexible, and, in many instances, appeared double-bordered. This stroma included minute cystic cavities, quite closely packed with cells, such as those described above.

A portion of the colloid matter, which was of clear amber colour, presented a sp. gr. 1017.8. Fifteen grammes of it evaporated to dryness yields a residue of .79 gramme. This yielded a blackish-gray ash, weighing .058 gramme, showing the amount of organic matter in 15 grammes to be .732 gramme. Five grammes, treated with fʒijss absolute alcohol, filtered, and filtrate evaporated, yielded of alcoholic extract .033 gramme. Five grammes, treated with fʒijss ether, filtered, and filtrate evaporated, yielded of ethereal extract .001 gramme.

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[1] A life-size water colour painting of this specimen was exhibited to the Society.

In answer to an allusion to the diagnostic value of the existence of urea in the fluid withdrawn by paracentesis, Dr. MITCHELL said that the presence of urea was so common under circumstances like these, that he was in doubt as to whether it could be considered of great importance. Thus it is found in the serum of the cavities of the brain, and the aqueous humour of the eye in health.

Dr. PEPPER said that he was aware that it was found in serous effusions, but he thought not in such noticeable quantity as in the present case, unless there has been obstruction to the circulation through the kidney, and interference with its function.

Syphilitic Ulceration of the Larynx.—Dr. S. W. GROSS presented the specimen, and read the following history of the case :—

E. W. S., 39 years of age, a plumber, of temperate habits and married, contracted chancre in 1857, for which he was treated with mercury, and which was followed, without being preceded by bubo, by secondary affections of the skin and throat, and finally, in about eight months, by ulceration of the tonsils and arches of the palate, the latter of which became ultimately firmly adherent to the posterior wall of the pharynx, so as completely to close the posterior nares. The bones of the skull became gradually affected, tender, enlarged, and exquisitely painful, especially at night and in damp states of the atmosphere. With the aid of the iodides, first of potassium, and, for the last twelve months, of sodium, the cranial suffering was kept in check, and the man was able, with occasional short intermission, to pursue his accustomed occupation. He was, however, remarkably susceptible to cold, and his appetite and strength not unfrequently failed him.

During the last three months of his life, he was much confined to his house, the osteocopic pains were very troublesome, and he now experienced great difficulty in his larynx, attended with occasional paroxysms of dyspnœa and of partial aphonia, the latter often continuing for days together. His countenance was wan and sallow, and his spirits were, at times, greatly depressed. A sense of uneasiness was complained of in the region of the stomach, but there was no actual pain or difficulty of deglutition at any period of the illness. The remedies which afforded most relief were iodide of sodium, with bichloride of mercury, and cauterization of the larynx with a solution of nitrate of silver, thirty grains to the ounce of water, every third or fourth day. Morphia and Dover's powder were frequently given at bedtime, and latterly, free use was made of quinia and milk-punch to support the failing strength. For the last week of his life, he suffered much from dyspnœa, and a sense of constriction in the windpipe; his debility greatly increased, but he was still able to be up, and was out two days before his death.

On May 17, he was suddenly seized with an aggravation of his laryngeal troubles, and when I saw him, four hours afterwards, he was tossing wildly about in his bed, panting for breath, exhibiting great difficulty of inspiration, and a peculiar whizzing sound, as if the air were passing through a narrow chink, as in œdema of the glottis. He became rapidly insensible, and expired in an hour after my arrival in a state of asphyxia. I would have opened the trachea, but had no instruments.

Twenty-four hours after death I examined the larynx, latterly the chief seat of the disease. The epiglottis was sound, but the vocal cords were thickened and indurated, and in such close contact as to leave hardly suf-